Thomas M. Siler, M.D.
Frank S. Calandrino, Jr., M.D.
Angela McDonnell, N.P.
Christine Champagne, N.P.
Renee Roesch, NP.

Welcome to Midwest Chest Consultants, P.C.

We are thrilled to welcome you to our office! To get started with your healthcare journey with us, please take a moment to review the attached new patient forms. Please note failure to have the forms completed in full prior to your appointment time will likely result in the appointment needing to be rescheduled to our first available spot. Please arrive 15 minutes early for registration and bring this completed paperwork with you to your appointment.

It is important to bring the following to every visit you have with our office:

- Photo ID
- Insurance Cards: Primary and Secondary (if applicable)
- Co-Payment: Due at time of service. We accept cash, check, money order, and debit/credit card (Visa, Mastercard, or Discover). There is an additional $25.00 fee for returned checks
- A list of your current medications and/or supplements

If you have any questions about the forms or need assistance completing them, please do not hesitate to contact our office at 636-946-1650 option 5 for the appointment line.

We look forward to meeting you and providing you with excellent care!

MIDWEST CHEST CONSULTANTS, P.C.
REGISTRATION FORM

Patient Name: (Last) ______________________________ (First) ________________________ (MI) ______

Date of Birth: ______/______/_______ Soc Sec #: ________________________ Sex: M F

Race: (Optional) _____________________________ Primary Language: ______________________________

Home #: ________________________ Cell #: ______________________ Work#: ______________________

Address: _________________________________ (City) ___________________ (State) _____ (Zip) ________

E-Mail: ____

Patient's Employer: ____

Which would you like to be contacted on first: (Circle) Home Cell Work

How would you like your confirmations for appointments: (Circle) Text Call E-mail

Marital Status: (Circle) Married Single Divorced Widowed Other: ________________

Spouse's Name: ___________________________________ Spouse's Date of Birth: ______/______/________

Emergency Contact:

Name: ____________________________ Relationship: ________________ Phone #: ___________________

Primary Care Physician: (Last) ______________________________ (First) _______________________

Phone #: _______________________________ City: _________________________________

PATIENT INFORMATION RELEASE (HIPAA REQUIRED)

Home:
□ Leave message with detailed information
□ Leave message with call back number only

Cell:
□ Leave message with detailed information
□ Leave message with call back number only

Please select ONE of the following:

□ OK to discuss medical information with: ____

(List names and relationships if left blank we will not be able to discuss anything with anyone. Including when your appointment is)

OR

□ Do **NOT** give out any information, even to family, unless specifically authorized. Medical information will be released to your primary physician and insurance company.

*** **RESEARCH:** Would you like to hear about how our research program may benefit you? Yes No ***

INSURANCE RELEASE INFORMATION

I hereby authorize the office of Midwest Chest Consultants, PC to release my insurance company any necessary information needed to file and expedite payment on my claim. I further assign any benefits payable on my behalf to my physician. I understand I am financially responsible for any balance not covered by my insurance carrier. In the case of a returned check there will be and additional $25.00 charge. I acknowledge the above information to be accurate.

PATIENT SIGNATURE: ____ DATE: ______/______/________

MIDWEST CHEST CONSULTANTS, P.C.
HEALTH HISTORY

Patient Name: ____ Date: ______/______/________

Patient Date of Birth: ______/______/________

Please describe your current complaint or reason you are seeing the doctor:

____

____

____

When did problem(s) begin? ______________________ Are complaints work related: Yes ______ No ______

ALLERGIES AND/OR MEDICINE REACTIONS

Do you have allergies or reactions to any medications/substance? Yes ________ No ________

If yes, type of reaction: (ex. Rash, swelling, etc…)

Rx/Substance: ____________________________________ Reaction: _____________________________________

Rx/Substance: ____________________________________ Reaction: _____________________________________

Rx/Substance: ____________________________________ Reaction: _____________________________________

Rx/Substance: ____________________________________ Reaction: _____________________________________

SMOKING/ALCOHOL HISTORY

Have you / Do you Smoke?

Never ______ Currently_______ Past/Quit_______ Date Quit ______/______/________

Packs per day_____________ Number of years________________

Other:

Pipe:_____ Cigar_____ Snuff____ Chew______ Marijuana______ Second Hand Smoke_______

Are you interested in quitting? Yes_________ No____________

Alcohol Consumption: None _____ Daily______ Weekly______ Monthly_______ Occasionally__________

What is your current activity level: Active __________ Sedentary________ House-Bound ___________

Have you traveled outside of the U.S. in the past five years? Yes _______ No _______

(If yes, where)____

Current Occupation: ____

MIDWEST CHEST CONSULTANTS, P.C.
HEALTH HISTORY

Date of last immunization: Influenza (Flu): ______________________
Pneumonia: ____________________ Type (Circle): Prevnar Pneumovax
Covid-19: _________________ Type (Circle): J&J Moderna Pfizer

HOSPITALIZATION / SURGERIES (NOT LISTED ELSEWHERE) – TYPE AND DATE

____ ____
____ ____
____ ____
____ ____

If you have ever had a listed condition in the past, please check the *Past* column.
If you are presently troubled by a listed condition, please check the *Present* column.
If you have not experienced a problem, please check the *Never* column.

	Past	Present	Never	
Cough	☐	☐	☐	Productive: Yes ___ No ___ Color ____________ Blood in Sputum: Yes ___ No___
Shortness of breath	☐	☐	☐	When: Activity ___ At Rest ___ Wakes Up at Night ___
Wheezing	☐	☐	☐	With Activity ___ Worse at Night ___
Lung Disease	☐	☐	☐	Emphysema ___ Asthma ___ Chronic Bronchitis ___ COPD_____
Heart Disease	☐	☐	☐	Heart Attack ___ CHF ___ Palpitations ___ Irregular Rhythm ___
Sinus/Nasal Problems	☐	☐	☐	Drainage ___ Color ____________ Congestion ___
High Blood Pressure	☐	☐	☐	
Stroke	☐	☐	☐	
Pain	☐	☐	☐	Location ____
Cancer	☐	☐	☐	Location _________________________________ When ________________________
Diabetes	☐	☐	☐	Insulin ___ Oral Medicines ___ Diet Controlled ___
Arthritis	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Congenital Disease	☐	☐	☐	
Immune Disease	☐	☐	☐	
Seizures	☐	☐	☐	
Headaches	☐	☐	☐	When: Any Time of Day ___ Morning ___ Evening ___
Weight Gain	☐	☐	☐	
Weight/loss	☐	☐	☐	
Depression	☐	☐	☐	
Anxiety	☐	☐	☐	
Sleep Problem	☐	☐	☐	Snoring ___ Gasping for Breath ___ Insomnia ___
Restless Legs	☐	☐	☐	During the Day ___ Worse at Night: Yes ___ No ___
Blood Clots	☐	☐	☐	Location _________________________________ When ________________________
Dizziness	☐	☐	☐	
Abnormal Chest X-Ray	☐	☐	☐	Location _________________________________ When ________________________
Other	☐	☐	☐	____

MIDWEST CHEST CONSULTANTS, P.C.
HEALTH HISTORY

FAMILY HX Parents	Father Alive Y N	Health Conditions/Cause of Death: ______________________________	Mother Alive Y N	Health Conditions/Cause of Death: __________________________________
Grandparents	Paternal Alive Grandfather Y N Grandmother Y N	Health Conditions/Cause of Death: ______________________________ ______________________________	Maternal Alive Grandfather Y N Grandmother Y N	Health Conditions/Cause of Death: __________________________________ __________________________________
Brothers	# Alive	Health Conditions:	# Deceased	Health Conditions/Cause of Death:
Sisters	# Alive	Health Conditions:	# Deceased	Health Conditions/Cause of Death:
Children Sons: Daughters:	# Alive	Ages & Health Conditions:	# Deceased	Ages & Health Conds./Causes of Death:

PHARMACY

Name and Location: ____ Phone #: (   ) ____________________

LIST OF CURRENT MEDICATIONS (may attach or use back-side of page)

NAME OF MEDICATION	STRENGTH	TIMES PER DAY	REASON/USED TO TREAT
____________________	__________	____________	____________________
____________________	__________	____________	____________________
____________________	__________	____________	____________________
____________________	__________	____________	____________________
____________________	__________	____________	____________________
____________________	__________	____________	____________________
____________________	__________	____________	____________________
____________________	__________	____________	____________________

OTHER CONCERNS/INFORMATION

____

____

____

____

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SLEEP HISTORY/LIFE HISTORY QUESTIONNAIRE

Today's Date: __________ / __________ / _____________
Month Day Year

Patient's Name: ____

Date of Birth: ___________ / _________ / ____________ Height: __________ Weight: _________
Month Day Year

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your sleep history. Please complete these questions as thoroughly as you can.

THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE

1. Describe your main sleep problem(s) in your own words, including when and how this began and what treatment you have received for this in the past.

____

____

____

____

____

____

2. How often does this problem occur?
   □ Almost every night
   □ For periods of at least 1 week
   □ Irregularly
   □ Other ____

3. How long has this problem bothered you?
   □ Longer than 2 years
   □ 1-2 years
   □ Several Months
   □ Within the last 3 months
   □ Within the last month

4. On the scale below, please estimate the severity of your problem(s).
   - □ Mildly upsetting
   - □ Moderately severe
   - □ Very severe
   - □ Extremely severe
   - □ Totally incapacitating

5. How strongly do you want help with your problem(s)?
   - □ Very much
   - □ Much
   - □ Moderately
   - □ Could do without it

6. How do you describe your sleep problem? Check all that apply to you.
   - □ Difficulty falling asleep
   - □ Wake up during the night
   - □ Wake up early in the morning
   - □ Excessive daytime sleepiness
   - □ Difficulty awakening

7. Do any other members of your family have sleep problems? Yes ______ No ______
   If yes, please explain.

____

____

____

____

8. Have you ever consulted with any of the following to help you with a sleep problem or daytime sleepiness?

□ General practitioner	□ Chiropractor	□ Obstetrician/Gynecologist
□ Cardiologist	□ Other Internists	□ Psychiatrist
□ Other Physician	□ Clinical Psychologist	□ Osteopath
□ Nutritionist	□ Counselor	□ Social Worker
□ Nurse	□ Clergyman	□ Other __________________

9. What treatments have you received?

____

____

____

Rating Scale: (please circle the letter that corresponds with your answer)

N=No or Never **R**=Rarely **O**=Occasionally **F**=Frequently **A**=Always **Y**=Yes

10. **Please Rate How Often You:**

Item						
• Snore	N	R	O	F	A	Y
• Snore loudly enough that others complain	N	R	O	F	A	Y
• Have trouble sleeping when you have a cold	N	R	O	F	A	Y
• Awaken from sleep short of breath	N	R	O	F	A	Y
• Suddenly wake up gasping for breath during the night	N	R	O	F	A	Y
• Have breathing problems during the night (noted by self or others)	N	R	O	F	A	Y
• Awaken at night with heartburn or belching	N	R	O	F	A	Y
• Awaken at night with cough	N	R	O	F	A	Y
• Sweat excessively at night	N	R	O	F	A	Y
• Notice heart pounding or beating irregularly at night	N	R	O	F	A	Y
• Fall asleep during the day	N	R	O	F	A	Y
• Fall asleep involuntarily	N	R	O	F	A	Y
• Fall asleep while driving	N	R	O	F	A	Y
• Have trouble at school or work because of sleepiness	N	R	O	F	A	Y
• Fall asleep or weakness during physical effort	N	R	O	F	A	Y
• Fall asleep or weakness while laughing or crying	N	R	O	F	A	Y
• Experience loss of muscle tone with extreme emotions	N	R	O	F	A	Y
• Unable to move when walking or falling asleep	N	R	O	F	A	Y
• Experience vivid dreamlike scenes upon awakening or falling asleep	N	R	O	F	A	Y
• Feel afraid of going to sleep	N	R	O	F	A	Y
• Have nightmares	N	R	O	F	A	Y
• Have thoughts racing through your mind	N	R	O	F	A	Y
• Feel sad or depressed	N	R	O	F	A	Y
• Have anxiety (worry about things)	N	R	O	F	A	Y
• Have muscular tension	N	R	O	F	A	Y
• Notice parts of your body jerk	N	R	O	F	A	Y
• Kick during the night	N	R	O	F	A	Y
• Experience crawling and achy feeling in your legs	N	R	O	F	A	Y
• Have morning jaw pain	N	R	O	F	A	Y
• Grind teeth during sleep	N	R	O	F	A	Y
• Are bothered by pain during the night	N	R	O	F	A	Y
• Wake up feeling stiff in the morning	N	R	O	F	A	Y
• Wake up with sore or achy muscles	N	R	O	F	A	Y
• Wake up with pain in neck, spine or joints	N	R	O	F	A	Y

11. Is your present work situation satisfactory? (Please explain)

____

____

12. **CHECK** any of the following that apply to you:

□ Headaches	□ No appetite	□ Feel panicky
□ Palpitations	□ Alcoholism	□ Suicidal ideas
□ Bowel disturbances	□ Take drugs	□ Sexual problems
□ Nightmares	□ Can't make decisions	□ Over-ambitious
□ Feels tense	□ Unable to have a good time	□ Memory problems
□ Financial problems	□ Depressed	□ Inferiority problems
□ Unable to relax	□ Tremors	□ Stomach trouble
□ Don't like weekends/vacations	□ Fainting Spells	□ Home conditions bad
□ Can't make friends	□ Concentration difficulties	□ Can't keep job
□ Shy with people	□ Take antacids regularly	

□ Others: ____

13. **CHECK** any of the following words that apply to you:

□ Worthless	□ useless	□ a "nobody"
□ "life is empty"	□ inadequate	□ stupid
□ incompetent	□ naïve	□ guilty
□ evil	□ morally wrong	□ horrible thoughts
□ hostile	□ full of hate	□ "can't do anything right"
□ full of regrets	□ anxious	□ agitated
□ cowardly	□ unassertive	□ panicky
□ aggressive	□ ugly	□ deformed
□ unattractive	□ depressed	□ lonely
□ unloved	□ misunderstood	□ bored
□ restless	□ confused	□ unconfident
□ worthwhile	□ sympathetic	□ intelligent
□ attractive	□ confident	□ considerate

□ Others:____

14. Does your sleep problem disturb your sex life? (Provide any information regarding significant relationships.)

____

____

____

____

____

15. Is your present social life satisfactory? Yes_________ No__________

If yes, does your sleep problem require you to cut back on social activity?

If so, how?

___

___

___

16. How many hours of sleep do you usually get per night? ___

17. What time do you usually go to bed on:

    WEEKDAYS?___ WEEKENDS?___

18. How long does it take for you to fall asleep? ___

19. How many times do you typically wake up at night? ___

20. If you “wake up,” on the average, how long do you stay awake? ___

21. If you awaken during the night (after you first fall asleep) which parts of your sleep period is it?

    □ soon after falling asleep □ middle of the night □ early morning

22. What do you usually do when you awaken during the night? ___

23. What time do you usually get out of bed on:

    WEEKDAYS?___ WEEKENDS?___

24. On average, how long do you stay in bed after waking up in the morning? ___

25. Do you usually: (check all that apply)

    □ sleep with someone in your bed
    □ sleep with someone else in your room
    □ provide assistance during the night (child, invalid, bed partner, animal)

26. Is your sleep often disturbed by: (check all that apply)

    □ heat □ light □ cold □ bed partner□ not being in your usual bed
    □ Other: ___

27. Are your sleep habits on the weekend different from the rest of week?

    If so please describe:

___

___

28. With whom are you now living?

- ☐ Wife Age __________
- ☐ Husband Age __________
- ☐ Children Age(s) ___________
- ☐ Parents Age(s) ___________
- ☐ Other Age(s) ___________

29. Do you work split shifts or rotating (variable) shifts? Yes __________ No ___________

30. Do you usually drink coffee or tea within 2 hours before you go to bed? Yes ____ No _____

31. Do you do physical exercise before bedtime? Yes __________ No __________

32. Do you read before falling asleep? Yes ___________ No ______________

33. Do you watch TV in bed before falling asleep? Yes ___________ No _______________

34. Do you take naps during the afternoon or evening? Yes ___________ No ____________

35. Do you feel refreshed after a short (10-15 minute) nap? Yes _________ No __________

36. How do you feel after an average night of sleep?

- ☐ Usually drowsy and/or tired
  If so, for how long: ☐ 1 hour ☐ 2 hours ☐ 3 hours or longer
- ☐ Most of the time, good
- ☐ Consistently good

37. Do you feel better during the:

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

38. List your consumption of the following per day:

Coffee_________________________________ Alcohol________________________________

Tea ___________________________________ Colas _________________________________

Chocolate _________________________ Over-the-Counter Drugs ________________________

Nicotine ________________________________ Other Drugs ______________________________

39. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to estimate how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation:

- Sitting and reading ________________
- Watching TV ________________
- Sitting, inactive in a public place (ex: a theater or a meeting) ________________
- As a passenger in a car for an hour without a break ________________
- Lying down to rest in the afternoon when circumstances permit ________________
- Sitting and talking with someone ________________
- Sitting quietly after a lunch without alcohol ________________
- In a car, while stopped for a few minutes in traffic ________________

40. What is your personal interpretation as to why you have your particular sleep/wake problem?

____

____

____

____

41. Please describe any other information pertinent to your sleep or wakefulness not previously described.

____

____

____